Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,390.24 for date of service, 03/25/02.

   b. The request was received on 06/07/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/29/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/29/02. The response from the insurance carrier was received in the Division on 09/12/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/08/02

   "After submitting our initial claim and also our request for reconsideration, the insurance carrier only paid us $3,509.76 total for code E0747 out of $5,900.00 that were [sic] billed for this item. Since there is no MAR for code E0747 (Bone Stimulator), we have enclosed EOBs from other insurance carriers that have reimbursed us for this same code. These EOBs should clearly prove and state that we are only asking to get reimbursed what is 'fair and reasonable' per our geographical area as TWCC Medical Fee Guidelines state."

2. Respondent: Letter dated 09/11/02

   "(Carrier) believes it has shown its method of determining fair and reasonable reimbursement, the same method that the (Carrier) uses consistently and has documented its claim file in compliance with 133.304 (i). The (Carrier) states again for all the parties to hear that the requester has never, that the (Carrier) knows of, given a monetary reason, explanation, or rationale why $5900.00 is a fair and reasonable payment. Consequently, it is the (Carrier's) position no additional payment can be made for the requester's bone growth stimulator until the requester clearly demonstrates $5900.00 is a fair and reasonable payment for the stimulator or that the (Carrier's) payment is not fair and reasonable."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date (s) of service eligible for review is 03/25/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,900.00 for durable medical equipment provided on the above date of service.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $3,509.76 for durable medical equipment provided on the above date of service.

5. The Carrier's EOBs deny reimbursement as, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)."

6. Per the Requestor's Table of Disputed Services, the Requestor is seeking $2,390.24 for durable medical equipment provided on the above date in dispute.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/25/02	E0747-NU	$5900.00	$3509.76	M	No MAR	MFG GI (VIII) (A); HCPCS descriptor	The modifier "NU" is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the services in dispute. Therefore, no reimbursement is recommended.
Totals		$5900.00	$3509.76				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 20th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt